STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING 01 B. WING	07/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 E 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification, State Licensure Survey and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 07/30/12 Facility Number: 000149 Provider Number: 155245 AIM Number: 100266840 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Castleton Health Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated	K0000	**K0000** **Element #1** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** It is the policy of this facility to ensure a fire alarm system required for life safety is installed, tested and maintained . That each and every resident room have a working, tested and monitored smoked detector. **Element #2** **How will you identify other residents having the potential to be affected by the same deficient** **practice and what corrective action will be taken;** All residents have the potential to be affected by this practice. Room 235 has a new smoke detector. The maintenance director or designee will monitor all rooms for smoke detectors weekly.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	smoke detectors in all resident sleeping rooms. The facility has a capacity of 109 and had a census of 62 at the time of this visit. The facility was found in compliance with the state law in regard to sprinkler coverage and was found not in compliance with the state law in regard to smoke detector coverage. All areas where the residents have customary access were sprinklered. The facility has one detached building providing facility services such as a laundry and a maintenance shop which were sprinklered. Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 08/02/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:		**Element #3** **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** At an all staff in-service held on Tuesday August 14, 2012 the need for smoke detectors in each and every resident room was discussed. **Element #4** **How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be put into place; and completion date.** At the monthly Quality Assurance meetings the results of the weekly monitoring by the maintenance director or designee was discuss. Any negative patterns will be addressed. If necessary, an action plan will be written by a committee appointed by the administrator. This plan will be monitored by the administrator until all goals are met.	

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K0025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to ensure 2 of 2 openings through the ceiling into the attic above the Mechanical Room was maintained to provide at least a one half hour fire resistance rating. This deficient practice could affect any resident, staff or visitor in the vicinity of the Mechanical Room by the Kitchen. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:45 a.m. to 12:55 p.m. on 07/30/12, there was a two foot diameter hole and a one inch by six inch opening in the ceiling of the Mechanical Room by the Kitchen which were not firestopped. Based on interview at the time of observation, the Maintenance Director stated a water leak damaged the ceiling	K0025	**F025** **Element #1** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** It is the policy of this facility to ensure that smoke barriers provide a one half hour fire resistance rating in accordance with 8.3. Smoke barriers. **Element #2** **How will you identify other residents**	08/16/2012

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	causing the two foot diameter hole in the ceiling and acknowledged the aforementioned openings in the ceiling of the Mechanical Room by the Kitchen were not firestopped. 3.1-19(b)		**having the potential to be affected by the same deficient practice and what corrective action will be taken;** The 2ft diameter hole and a one inch by six inch opening in the ceiling of the Mechanical Room by the Kitchen which were not fire stopped has been repaired. The maintenance director or designee will continue to monitor all potential breaches after damage or repairs. All clear or fixed repairs will be given to the administrator. **Element #3** **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** At an in-service held Tuesday August 14, 2012 the aspects of fire breaches was discuss. **Element #4** **How the corrective**	

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			actions will be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be **put into place; and completion** At the monthly quality assurance meeting the reports of breaches was reviewed any reports of negative results the Administrator shall appoint a review team to monitor and report until resolved.	

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K0029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 2 of 2 soiled linen receptacles in the corridor near Room 107 were stored in an enclosure having a one fire resistance rating. This deficient practice could affect any resident, staff or visitor in the vicinity of Room 107. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 10:45 a.m. to 12:55 p.m. on 07/30/12, two 32 gallon capacity mobile soiled linen receptacles each contained soiled linen and were unattended and stored next to each other in the corridor by Room 107. Based on interview at the time of observation, the Maintenance Director acknowledged mobile soiled linen receptacles with more than 32 gallons capacity were not stored in an area	K0029	**K 029 Element #1** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** It is the policy of this facility to ensure that 32 gallon mobile soiled linen or trash collection receptacles are at a distance of not less than 64 square foot area of each other. The 32 mobile soiled linen or trash collection receptacles are at a greater distance than 64 square feet of each other at this time. **Element #2** ***How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;*** All residents have the potential to be affected by this practice. The maintenance director or designee will monitor that the 32 gallon mobile soiled linen and trash collection receptacles are not less than 64 square feet from each other. This	08/16/2012

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	providing a one hour fire fire resistance rating. 3.1-19(b)		weekly checking will be (3) times weekly on-going and will become part of the preventive maintenance done by the maintenance department. After (4) weeks of 100% compliance this monitoring will be once weekly. Any negative findings will be corrected as found. **Element #3** ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;*** At an all staff in-service held on Tuesday August 14, 2012 the need to keep the 32 gallon mobile soiled linen and trash collection receptacles at a greater distance than 64 square feet (8)ft by (8) was discussed. Any staff who fail to comply will be progressively discipline as appropriate**.** **Element #4** ***How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be put into place; and completion date.*** At the monthly Quality Assurance meetings the results of the monitoring by the maintenance director or designee Any negative patterns will be addressed. If necessary, an action plan will be written by a committee appointed by the administrator. This plan will be monitored by the administrator until all goals are met.	

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K0038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure the means of egress through 2 of 7 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the residents require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice affects any resident, staff or visitor needing to exit the facility by Room 134 and by Room 201. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:45 a.m. to 12:55 p.m. on 07/30/12, seven exit doors were magnetically locked and could be opened by entering a four digit code but the code	K0038	**K 038** **Element #1** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** It is the policy of this facility to see that staff, visitors etc… readily access and egress through all exits. Access codes have been posted at each key pad exit. **Element #2** **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All person who enter the facility have the potential to be affected by this practice. All exits which have key pads now have the code posted above the exit. The maintenance director or his/her designee will monitor	08/16/2012

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	was not posted at the exit door by Room 134 and by Room 201. Based on interview with the Maintenance Director at the time of the observations, the residents who have a clinical diagnosis to be in a secure building are housed in the secure memory care area and not near the aforementioned facility exits. The Maintenance Director went on to say, a resident without the clinical diagnosis requiring specialized security measures would have to ask a staff member to let them out if they did not know the exit access code. Based on interview at the time of the observations, the Maintenance Director acknowledged the four digit exit code was not posted at the facility exit by Room 134 and by Room 201. 3.1-19(b)		monthly all exits with key pads to ensure codes are posted. This monthly checking will be on-going. Any negative findings will be corrected immediately. **Element #3** What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; At an all staff in-service held on Tuesday August 14, 2012, the need to have codes posted above all key pad exits was discussed. **Element #4** **How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be** **put into place; and completion date.** At the monthly Quality Assurance meetings the results of the rounds made by the administrator or designee was reviewed. Any patterns will be addressed. If necessary, an action plan will be written by a committee appointed by the administrator. This plan will be monitored weekly by the administrator until all goals are met.	

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K0050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on 1 of 3 shifts for 3 of 4 quarters. This deficient practice affects all occupants in the facility. Findings include: Based on a review of "Fire Drill Report" documentation with the Maintenance Director during record review from 9:15 a.m. to 10:45 a.m. on 07/30/12, third shift fire drills conducted on 11/16/11, 03/28/12 and 07/11/12 were conducted, respectively, at 4:55 a.m., 4:40 a.m. and 4:00 a.m. Based on interview at the time of record review, the Maintenance Director acknowledged third shift fire drills were not conducted at unexpected times under varying conditions. 3.1-19(b)	K0050	**K50** **Element #1** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** It is the policy of this facility to ensure that quarterly fire drills on each shift for all (4) quarters annually. **Element #2** **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by this practice. The maintenance director or designee will monitor all fire drills monthly to ensure they are being	08/16/2012

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			conducted regularly and at different times and days throughout the week or time period per NFPA 101 Life Safety Standard. This monthly check of all fire drills will be given to the administrator or designee at the last day of each month. This weekly checking will be on-going. Any negative findings will be corrected immediately. **Element #3** **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** At an all staff in-service held on Tuesday February 03, 2009 the need to have fire drills on each shift for 1 of 4 quarters and at unexpected times was discussed. **Element #4** **How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be put into place; and completion date.** At the monthly Quality Assurance meetings the results of the monthly monitoring by the maintenance director or designee	

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			and the administrator or designee was discuss. Any negative patterns will be addressed. If necessary, an action plan will be written by a committee appointed by the administrator. This plan will be monitored by the administrator until all goals are met.	

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K0052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on observation and interview, the facility failed to maintain 2 of 36 smoke detectors in accordance with NFPA 72. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, smoke detectors shall not be located where airflow prevents operation of the detectors. NFPA 72, A-2-3.5.1 explains smoke detectors should not be located in a direct airflow nor closer than 3 feet from an air supply diffuser or return air opening. This deficient practice could affect residents, staff or visitors in the corridor in the vicinity of the Custom Boulevard smoke wall cross corridor door set and in the vicinity of the Marshall smoke wall cross corridor door set. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:45 a.m. to 12:55 p.m. on 07/30/12, the smoke detector in the corridor next to the Custom Boulevard smoke wall cross corridor door set and in	K0052	**K052** **Element #1** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** It's the policy of this facility to ensure that a fire alarm system require for life safety is maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. Custom Boulevard ceiling fans by the smoke wall cross corridor door set and in the corridor next to the Marshall smoke wall cross corridor door set blades have been remove and will never be put back. **Element #2** ***How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;*** All resident have the potential to	08/16/2012

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	the corridor next to the Marshall smoke wall cross corridor door set were each located in the ceiling within one foot of a ceiling fan. Based on interview at the time of the observations, the Maintenance Director acknowledged the two smoke detectors were each installed within one foot of a ceiling fan at the aforementioned locations. 3.1-19(b)		be affected by this practice. The maintenance director or designee will monitor all hard wired smoke detectors monthly to ensure no interference has been established. **Element #3** ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;*** At an in-service held August 14, 2012 the ceiling fans and there interference was discussed. **Element #4** ***How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be*** ***put into place; and completion date.*** At the monthly Quality Assurance meetings the results of the monthly monitoring by the maintenance director or designee was discuss. Any negative patterns will be addressed. If necessary, an action plan will be written by a committee appointed by the administrator. This plan will be monitored by the administrator until all goals are met.	

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K0064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to inspect 1 of 11 portable fire extinguishers in the facility each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying that it is in its designated place, it has not been actuated or tampered with and there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect any staff or visitor in the vicinity of the Laundry Room. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 10:45 a.m. to 12:55 p.m. on 07/30/12, the annual maintenance tag attached to the portable fire extinguisher located in the soiled side of the Laundry	K0064	**K 064** **Element #1** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** It is the policy of this facility to ensure that fire extinguishers are inspected monthly for working compliance. **Element #2** **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by this practice. The maintenance director or designee will monitor the fire extinguishers monthly to ensure this practice is being completed. **Element #3** **What measures will be put into place or what systemic changes you will make to**	08/16/2012

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	155245	A. BUILDING 01 B. WING	07/30/2012

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	Room indicated the last monthly inspection for this portable fire extinguisher was performed in January 2012. Based on interview at the time of observation, the Maintenance Director stated he was unaware a fire extinguisher was located in the soiled side of the Laundry Room and acknowledged the most recent monthly inspection for this portable extinguisher was performed January 2012. 3.1-19(b)		**ensure that the deficient practice does not recur;** At an all staff in-service held on Tuesday August 14, 2012 the need to monitor fire extinguishers monthly was discussed. **Element #4** **How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be put into place; and completion date.** At the monthly Quality Assurance meetings the results of the monitoring by the maintenance director or designee was discussed. Any negative patterns will be addressed. If necessary, an action plan will be written by a committee appointed by the administrator. This plan will be monitored by the administrator until all goals are met.	

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K0075 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5 Based on observation and interview, the facility failed to ensure a capacity of 32 gallons for mobile soiled linen or trash collection receptacles was not exceeded within any 64 square feet area for 1 of 7 corridors. This deficient practice could affect any resident, staff or visitor in the vicinity of Room 107. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 10:45 a.m. to 12:55 p.m. on 07/30/12, two 32 gallon capacity mobile soiled linen receptacles each contained soiled linen and were unattended and stored next to each other in the corridor by Room 107. Based on interview at the time of observation, the Maintenance Director acknowledged mobile soiled linen receptacles with a capacity of more than 32 gallons were stored within the 64	K0075	**K 075** **Element #1** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** It is the policy of this facility to ensure that 32 gallon mobile soiled linen or trash collection receptacles are at a distance of not less than 64 square foot area of each other. The 32 mobile soiled linen or trash collection receptacles are at a greater distance than 64 square feet of each other at this time. **Element #2** **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;**	08/16/2012

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	square feet corridor area near Room 107. 3.1-19(b)		All residents have the potential to be affected by this practice. The maintenance director or designee will monitor that the 32 gallon mobile soiled linen and trash collection receptacles are not less than 64 square feet from each other. This weekly checking will be (3) times weekly on-going and will become part of the previous maintenance done by the maintenance department. After (4) weeks of 100% compliance this monitoring will be once weekly. Any negative findings will be corrected as found. **Element #3** **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** At an all staff in-service held on Tuesday August 14, 2012 the need to keep the 32 gallon mobile soiled linen and trash collection receptacles at a greater distance than 64 square feet (8)ft by (8) was discussed. Any staff who fail to comply will be progressively discipline as appropriate. **Element #4** **How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what quality**	

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			assurance program will be put into place; and completion date. At the monthly Quality Assurance meetings the results of the monitoring by the maintenance director or designee Any negative patterns will be addressed. If necessary, an action plan will be written by a committee appointed by the administrator. This plan will be monitored by the administrator until all goals are met.	

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K0143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to ensure 1 of 1 liquid oxygen storage areas where oxygen transferring takes place, was enclosed by a 1 hour fire resistive enclosure. NFPA 80, the Standard for fire Doors and Fire Windows at 2-4.1.4 requires all closing mechanisms shall be adjusted to overcome the resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice could affect residents, staff and visitors in the vicinity of the ICF area storage room. Findings include: Based on observation with the Maintenance Director during a tour of the	K0143	**K 143** **Element #1** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** It is the policy of this facility to see all doors serving hazardous areas such as the oxygen storage room close and latch to prevent the passage of smoke. The oxygen storage room without the proper closure and latch has been repaired. **Element #2** ***How will you identify other***	08/16/2012

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	facility from 10:45 a.m. to 12:55 p.m. on 07/30/12, the oxygen storage and transfilling room is connected to the ICF area storage room. The entry door to the oxygen storage and transfilling room latching hardware was not secured into the door which caused the door to not latch into the door frame. Based on interview at the time of observation, the Maintenance Director acknowledged the oxygen storage and transfilling room entry door latching hardware was not secured which caused the entry door to not latch into the door frame. 3.1-19(b)		***residents having the potential to be affected by the same deficient practice and what corrective action will be taken;*** All residents have the potential to be affected by this practice. A facility wide audit was conducted to ensure all doors serving hazardous areas have the proper closure apparatus and latching hardware required to allow proper closure. The maintenance director or designee will do a monthly audit of all doors serving hazardous areas for proper closing and latching. This monthly checking will be on-going and will become part of the preventive maintenance done by the maintenance department. Any negative findings will be corrected as found. **Element #3** ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;*** At an all staff in-service held on Tuesday August 14, 2012 the need to ensure all doors serving hazardous areas and proper closing and latching procedures was discussed. Any door found to not close or latch by staff that a	

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			maintenance request is completed was emphasized. Maintenance monthly rounds to check hazardous areas doors and proper closing and latching was also discussed. Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as appropriate. **Element #4** ***How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be put into place; and completion date.*** At the monthly Quality Assurance meetings the results of the rounds made by the Maintenance Supervisor or their designee will be reviewed. Any patterns will be addressed. If necessary, an action plan will be written by a committee appointed by the administrator. This plan will be monitored weekly by the administrator until all goals are met.	

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K9999	State Findings 3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS 3.1-19(ff) A health facility licensed under 16-28 and this rule must do the following: (1) Have an automatic sprinkler system installed throughout the facility before July 1, 2012. (2) If an automatic sprinkler system is not installed throughout the health care facility before July 1, 2010, submit before July 1, 2010 a plan to the department for completing the installation of the automatic sprinkler system before July 1, 2012. (3) Have a battery operated or hard-wired smoke detector in each resident's room before July 1, 2012. This State Rule has not been met as evidenced by: Based on observation and interview, the facility failed to install smoke detectors in 1 of 60 resident rooms before July 1, 2012. This deficient practice could affect 2 residents in the facility. Findings include: Based on observation with the	K9999	**K 9999** **Element #1** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** It is the policy of this facility to ensure a fire alarm system required for life safety is installed, tested and maintained . That each and every resident room have a working, tested and monitored smoked detector. **Element #2** **How will you identify other residents having the potential to be affected by the same deficient** **practice and what corrective action will be taken;** All residents have the potential to be affected by this practice. Room 235 has a new smoke detector. The maintenance director or designee will monitor all rooms for smoke detectors weekly.	08/16/2012

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	Maintenance Director during a tour of the facility from 10:45 a.m. to 12:55 p.m. on 07/30/12, a smoke detector was not installed in resident sleeping room #235. Based on interview at the time of observation, the Maintenance Director acknowledged a smoke detector was not installed in resident sleeping room #235. 3.1-19(ff)		**Element #3** **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** At an all staff in-service held on Tuesday August 14, 2012 the need for smoke detectors in each and every resident room was discussed. **Element #4** **How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be put into place; and completion date.** At the monthly Quality Assurance meetings the results of the weekly monitoring by the maintenance director or designee was discuss. Any negative patterns will be addressed. If necessary, an action plan will be written by a committee appointed by the administrator. This plan will be monitored by the administrator until all goals are met.	